

## ZERO INCOME VERIFICATION

I, \_\_\_\_\_, on this day of \_\_\_\_\_  
Witness Name and Phone Number (please print) (Today's Date)

verify that \_\_\_\_\_ receives \$ \_\_\_\_\_ income  
Applicant Name  
per month.

### **Present Living Arrangement:**

- |                                       |                                       |   |
|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Homeless     | <input type="checkbox"/> Alone        |   |
| <input type="checkbox"/> Hospital     | <input type="checkbox"/> With Family  | <input type="checkbox"/> Shelter/Mission              |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> With Friends | <input type="checkbox"/> Other (please explain) _____ |
| _____                                 |                                       |   |
| _____                                 |                                       |   |

Does anyone provide food or clothing for you? ☐ Yes ☐ No

Can anyone claim you on his or her income taxes? ☐ Yes ☐ No

**Will you, or have you applied for:** ☐ **Yes, will or have applied for:** ☐ **No, have not applied**

- |                                       |                                     |                                 |
|---------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Unemployment | <input type="checkbox"/> Employment | <input type="checkbox"/> School |
| <input type="checkbox"/> Medicaid     | <input type="checkbox"/> Medicare   | <input type="checkbox"/> None   |

\*\*\*\*\*  
**Please explain how you are paying for your housing, food, and other necessities:**

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If you receive public assistance, provide verification of the type and amount of assistance you receive. Public assistance may include financial assistance, Medicaid, food stamps, subsidized housing, etc.

**I hereby declare that all information provided by me on this form is complete and true to the best of my knowledge and belief. I agree to notify the Addictive & Mental Disorders Division at 1-888-866-0328 of any changes in the above information as soon as possible, but within 30 days of my knowledge of the change.**

**Applicant's Signature:**   X   **Date:** \_\_\_\_\_

**Applicant's Address:** \_\_\_\_\_ **Soc. Sec. #:** \_\_\_\_\_

\_\_\_\_\_

**Witness Signature:**   X   **Date:** \_\_\_\_\_